

# Senate Study Bill 3003 - Introduced

SENATE FILE \_\_\_\_\_  
BY (PROPOSED COMMITTEE ON  
HUMAN RESOURCES BILL BY  
CHAIRPERSON SEGEBART)

## A BILL FOR

1 An Act relating to continuity of care and nonmedical switching  
2 by health carriers, health benefit plans, and utilization  
3 review organizations, and including applicability  
4 provisions.

5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1     Section 1. NEW SECTION.   514F.8   Continuity of care —  
2 nonmedical switching.

3     1. *Definitions.* For the purpose of this section:

4     *a. "Authorized representative"* means the same as defined in  
5 section 514J.102.

6     *b. "Commissioner"* means the commissioner of insurance.

7     *c. "Cost sharing"* means any coverage limit, copayment,  
8 coinsurance, deductible, or other out-of-pocket expense  
9 requirement.

10    *d. "Coverage exemption"* means a determination made by a  
11 health carrier, health benefit plan, or utilization review  
12 organization to cover a prescription drug that is otherwise  
13 excluded from coverage.

14    *e. "Coverage exemption determination"* means a determination  
15 made by a health carrier, health benefit plan, or utilization  
16 review organization whether to cover a prescription drug that  
17 is otherwise excluded from coverage.

18    *f. "Covered person"* means the same as defined in section  
19 514J.102.

20    *g. "Discontinued health benefit plan"* means a covered  
21 person's existing health benefit plan that is discontinued by a  
22 health carrier during open enrollment for the next plan year.

23    *h. "Formulary"* means a complete list of prescription drugs  
24 eligible for coverage under a health benefit plan.

25    *i. "Health benefit plan"* means the same as defined in  
26 section 514J.102.

27    *j. "Health care professional"* means the same as defined in  
28 section 514J.102.

29    *k. "Health care services"* means the same as defined in  
30 section 514J.102.

31    *l. "Health carrier"* means the same as defined in section  
32 514J.102.

33    *m. "Nonmedical switching"* means a health benefit plan's  
34 restrictive changes to the health benefit plan's formulary  
35 after the current plan year has begun or during the open

1 enrollment period for the upcoming plan year, causing a covered  
2 person who is medically stable on the covered person's current  
3 prescribed drug as determined by the prescribing health care  
4 professional, to switch to a less costly alternate prescription  
5 drug.

6     *n. "Open enrollment"* means the yearly time period an  
7 individual can enroll in a health benefit plan.

8     *o. "Utilization review"* means the same as defined in 514F.7.

9     *p. "Utilization review organization"* means the same as  
10 defined in 514F.7.

11     2. *Nonmedical switching.* With respect to a health carrier  
12 that has entered into a health benefit plan with a covered  
13 person that covers prescription drug benefits, all of the  
14 following apply:

15     *a.* A health carrier, health benefit plan, or utilization  
16 review organization shall not limit or exclude coverage of  
17 a prescription drug for any covered person who is medically  
18 stable on such drug as determined by the prescribing health  
19 care professional, if all of the following apply:

20         (1) The prescription drug was previously approved by the  
21 health carrier for coverage for the covered person.

22         (2) The covered person's prescribing health care  
23 professional continues to prescribe the drug for the medical  
24 condition.

25         (3) The covered person continues to be an enrollee of the  
26 health benefit plan.

27     *b.* Coverage of a covered person's prescription drug, as  
28 described in paragraph "a", shall continue through the last day  
29 of the covered person's eligibility under the health benefit  
30 plan, inclusive of any open enrollment period.

31     *c.* Prohibited limitations and exclusions referred to in  
32 paragraph "a" include but are not limited to the following:

33         (1) Limiting or reducing the maximum coverage of  
34 prescription drug benefits.

35         (2) Increasing cost sharing for a covered prescription

1 drug.

2 (3) Moving a prescription drug to a more restrictive tier if  
3 the health carrier uses a formulary with tiers.

4 (4) Removing a prescription drug from a formulary.

5 3. *Coverage exemption determination process.*

6 a. To ensure continuity of care, a health carrier, health  
7 plan, or utilization review organization shall provide a  
8 covered person and prescribing health care professional with  
9 access to a clear and convenient process to request a coverage  
10 exemption determination. A health carrier, health plan, or  
11 utilization review organization may use its existing medical  
12 exceptions process to satisfy this requirement. The process  
13 used shall be easily accessible on the internet site of the  
14 health carrier, health benefit plan, or utilization review  
15 organization.

16 b. A health carrier, health benefit plan, or utilization  
17 review organization shall respond to a coverage exemption  
18 determination request within seventy-two hours of receipt. In  
19 cases where exigent circumstances exist, a health carrier,  
20 health benefit plan, or utilization review organization shall  
21 respond within twenty-four hours of receipt. If a response by  
22 a health carrier, health benefit plan, or utilization review  
23 organization is not received within the applicable time period,  
24 the coverage exemption shall be deemed granted.

25 (1) A coverage exemption shall be expeditiously granted for  
26 a discontinued health benefit plan if a covered person enrolls  
27 in a comparable plan offered by the same health carrier, and  
28 all of the following conditions apply:

29 (a) The covered person is medically stable on a prescription  
30 drug as determined by the prescribing health care professional.

31 (b) The prescribing health care professional continues  
32 to prescribe the drug for the covered person for the medical  
33 condition.

34 (c) In comparison to the discontinued health benefit plan,  
35 the new health benefit plan does any of the following:

- 1 (i) Limits or reduces the maximum coverage of prescription  
2 drug benefits.
- 3 (ii) Increases cost sharing for the prescription drug.
- 4 (iii) Moves the prescription drug to a more restrictive tier  
5 if the health carrier uses a formulary with tiers.
- 6 (iv) Excludes the prescription drug from the formulary.
- 7 c. Upon granting of a coverage exemption for a drug  
8 prescribed by a covered person's prescribing health care  
9 professional, a health carrier, health benefit plan, or  
10 utilization review organization shall authorize coverage no  
11 more restrictive than that offered in a discontinued health  
12 benefit plan, or than that offered prior to implementation of  
13 restrictive changes to the health benefit plan's formulary  
14 after the current plan year began.
- 15 d. If a determination is made to deny a request for a  
16 coverage exemption, the health carrier, health benefit plan,  
17 or utilization review organization shall provide the covered  
18 person or the covered person's authorized representative and  
19 the authorized person's prescribing health care professional  
20 with the reason for denial and information regarding the  
21 procedure to appeal the denial. Any determination to deny a  
22 coverage exemption may be appealed by a covered person or the  
23 covered person's authorized representative.
- 24 e. A health carrier, health benefit plan, or utilization  
25 review organization shall uphold or reverse a determination to  
26 deny a coverage exemption within seventy-two hours of receipt  
27 of an appeal of denial. In cases where exigent circumstances  
28 exist, a health carrier, health benefit plan, or utilization  
29 review organization shall uphold or reverse a determination to  
30 deny a coverage exemption within twenty-four hours of receipt.  
31 If the determination to deny a coverage exemption is not upheld  
32 or reversed on appeal within the applicable time period, the  
33 denial shall be deemed reversed and the coverage exemption  
34 shall be deemed approved.
- 35 f. If a determination to deny a coverage exemption is

1 upheld on appeal, the health carrier, health benefit plan,  
2 or utilization review organization shall provide the covered  
3 person or covered person's authorized representative and the  
4 covered person's prescribing health care professional with  
5 the reason for upholding the denial on appeal and information  
6 regarding the procedure to request external review of the  
7 denial pursuant to chapter 514J. Any denial of a request for a  
8 coverage exemption that is upheld on appeal shall be considered  
9 a final adverse determination for purposes of chapter 514J and  
10 is eligible for a request for external review by a covered  
11 person or the covered person's authorized representative  
12 pursuant to chapter 514J.

13 4. *Limitations.* This section shall not be construed to do  
14 any of the following:

15 a. Prevent a health care professional from prescribing  
16 another drug covered by the health carrier that the health care  
17 professional deems medically necessary for the covered person.

18 b. Prevent a health carrier from doing any of the following:

19 (1) Adding a prescription drug to its formulary.

20 (2) Removing a prescription drug from its formulary if the  
21 drug manufacturer has removed the drug for sale in the United  
22 States.

23 5. *Enforcement.* The commissioner may take any enforcement  
24 action under the commissioner's authority to enforce compliance  
25 with this section.

26 6. *Applicability.* This Section is applicable to a health  
27 benefit plan that is delivered, issued for delivery, continued,  
28 or renewed in this state on or after January 1, 2019.

29 EXPLANATION

30 The inclusion of this explanation does not constitute agreement with  
31 the explanation's substance by the members of the general assembly.

32 This bill relates to the continuity of care for a covered  
33 person and nonmedical switching by health carriers, health  
34 benefit plans, and utilization review organizations.

35 The bill defines "nonmedical switching" as a health benefit

1 plan's restrictive changes to the health benefit plan's  
2 formulary after the current plan year has begun or during the  
3 open enrollment period for the upcoming plan year, causing a  
4 covered person who is medically stable on the covered person's  
5 current prescribed drug as determined by the prescribing  
6 health care professional, to switch to a less costly alternate  
7 prescription drug.

8     The bill provides that during a covered person's eligibility  
9 under a health benefit plan, inclusive of any open enrollment  
10 period, a health plan carrier, health benefit plan, or  
11 utilization review organization shall not limit or exclude  
12 coverage of a prescription drug for the covered person if the  
13 covered person is medically stable on the drug as determined  
14 by the prescribing health care professional, the drug was  
15 previously approved by the health carrier for coverage for the  
16 person, and the person's prescribing health care professional  
17 continues to prescribe the drug. The bill includes, as  
18 prohibited limitations or exclusions, reducing the maximum  
19 coverage of prescription drug benefits, increasing cost sharing  
20 for a covered drug, moving a drug to a more restrictive tier,  
21 and removing a drug from a formulary.

22     The bill requires a covered person and prescribing health  
23 care professional to have access to a process to request a  
24 coverage exemption determination. The bill defines "coverage  
25 exemption determination" as a determination made by a  
26 health carrier, health benefit plan, or utilization review  
27 organization whether to cover a prescription drug that is  
28 otherwise excluded from coverage.

29     A coverage exemption determination request must be approved  
30 or denied by the health carrier, health benefit plan, or  
31 utilization review organization within 72 hours, or within 24  
32 hours if exigent circumstances exist. If a determination is  
33 not received within the applicable time period the coverage  
34 exemption is deemed granted.

35     The bill requires a coverage exemption to be expeditiously

1 granted for a health benefit plan discontinued for the next  
2 plan year if a covered person enrolls in a comparable plan  
3 offered by the same health carrier, and in comparison to the  
4 discontinued health benefit plan, the new health benefit plan  
5 limits or reduces the maximum coverage for a prescription drug,  
6 increases cost sharing for the prescription drug, moves the  
7 prescription drug to a more restrictive tier, or excludes the  
8 prescription drug from the formulary.

9 If a coverage exemption is granted, the bill requires the  
10 authorization of coverage that is no more restrictive than that  
11 offered in a discontinued health benefit plan, or than that  
12 offered prior to implementation of restrictive changes to the  
13 health benefit plan's formulary after the current plan year  
14 began.

15 If a determination is made to deny a request for a  
16 coverage exemption, the reason for denial and the procedure  
17 to appeal the denial must be provided to the requestor. Any  
18 determination to deny a coverage exemption may be appealed to  
19 the health carrier, health benefit plan, or utilization review  
20 organization.

21 A determination to uphold or reverse denial of a coverage  
22 exemption must be made within 72 hours of receipt of an appeal,  
23 or within 24 hours if exigent circumstances exist. If a  
24 determination is not made within the applicable time period,  
25 the denial is deemed reversed and the coverage exemption is  
26 deemed approved.

27 If a determination to deny a coverage exemption is upheld on  
28 appeal, the reason for upholding the denial and the procedure  
29 to request external review of the denial pursuant to Code  
30 chapter 514J must be provided to the individual who filed the  
31 appeal. Any denial of a request for a coverage exemption that  
32 is upheld on appeal is considered a final adverse determination  
33 for purposes of Code chapter 514J and is eligible for a request  
34 for external review by a covered person or the covered person's  
35 authorized representative pursuant to Code chapter 514J.



1     The bill shall not be construed to prevent a health care  
2 professional from prescribing another drug covered by the  
3 health carrier that the health care professional deems  
4 medically necessary for the covered person.

5     The bill shall not be construed to prevent a health carrier  
6 from adding a drug to its formulary or removing a drug from its  
7 formulary if the drug manufacturer removes the drug for sale in  
8 the United States.

9     The bill allows the commissioner to take any necessary  
10 enforcement action under the commissioner's authority to  
11 enforce compliance with the bill.

12    The bill is applicable to health benefit plans that are  
13 delivered, issued for delivery, continued, or renewed in this  
14 state on or after January 1, 2019.